	HFO		CMV			Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Random, 95% C	I M-H, Random, 95% CI
Bollen 2005 (12)	16	37	8	24	10.2%	1.30 [0.66, 2.55]	 -
Demory 2007 (6)	4	13	4	15	4.5%	1.15 [0.36, 3.72]	
Derdak 2002 (13)	28	75	38	73	18.3%	0.72 [0.50, 1.03]	
Ferguson 2013 (11)	129	275	96	273	23.8%	1.33 [1.09, 1.64]	
Mentzelopoulos 2012 (2)	23	61	41	64	18.2%	0.59 [0.41, 0.85]	- -
Young 2013 (7)	166	398	163	397	24.9%	1.02 [0.86, 1.20]	†
Total (95% CI)		859		846	100.0%	0.95 [0.72, 1.25]	•
Total events	366		350				
Heterogeneity: $Tau^2 = 0.07$; $Chi^2 = 19.15$, $df = 5$ (P = 0.002); $I^2 = 74\%$							0.01 0.1 1 10 100
Test for overall effect: Z = 0.37 (P = 0.71)							0.01

Fig. 1. Corrected forest plot of the risk ratio of 30-day, or intensive care unit, or in-hospital mortality in the studies included in the meta-analysis of Maitra *et al.*¹ Numbers in parentheses correspond to current article references. CMV = conventional mechanical ventilation (corresponding to standard treatment); HFO = high-frequency oscillation (corresponding to experimental treatment); M-H = Mantel-Haenszel.

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In Reply:

We have read the letter by Mentzelopoulos et al. regarding the possible inaccuracy in a few outcomes of our analysis. We sincerely apologize for the possible duplication of a few patients from inclusion of a previous study.² Although this error is purely unintentional, we are sorry to say that we were unable to find a statement regarding overlapping of the patients in the Methods section of the later study.³ However, a reanalysis of our primary outcome did not change the primary finding of our meta-analysis (fig. 1). Mentzelopoulos et al. correctly reported that I^2 , which is the heterogeneity value, and CI, are different. We have already used a random effect model in all our analysis even if the I^2 value is low due to possible clinical heterogeneity in the included studies. The 95% CI is used to estimate the precision of the odds ratio.4 If a 95% CI for the odds ratio does not include 1 (the null value), then the odd ratios are said to be statistically significantly different. We also accept the possibility of biases from inclusion of the randomized controlled trial by Demory et al.5 However, reanalyzing in-hospital/30-day/intensive care unit

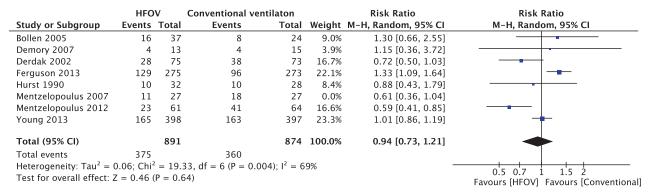


Fig. 1. Corrected forest plot for in-hospital/intensive care unit/30-day mortality. HFOV = high-frequency oscillatory ventilation; M-H = Mantel-Haenszel.

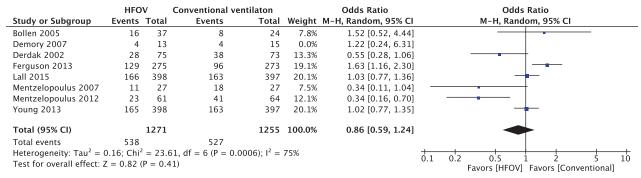


Fig. 2. Forest plot of in-hospital/intensive care unit/30-day mortality (excluding the study by Demory *et al.*⁵). HFOV = high-frequency oscillatory ventilation; M-H = Mantel-Haenszel.

mortality excluding Demory *et al.*'s trial did not change our primary findings (fig. 2). Kindly refer to figure 3 of the study by Young *et al.*, ⁶ which clearly mentions that the number of survivors at day 30 was 233 in the high-frequency oscillatory ventilation group. After exclusion of the preliminary findings of Mentzelopoulos *et al.*, ² duration of mechanical ventilation and incidence of barotrauma remain unchanged from our primary findings.

Competing Interests

The authors declare no competing interests.

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